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Q: Does the practice of “post-consumption” or retrospective billing in long-term-care pharmacies have to be accommodated by Part D plans under the Medicare Prescription Drug Benefit?

A: CMS interprets the term “post-consumption” or retrospective billing as generally referring to billing that is performed after the drug is dispensed, usually at the end of the month (or the beginning of the next month). While this is not typically utilized in the retail setting, it is commonplace within the long-term care arena, especially in certain parts of the country. A significant advantage of this type of billing is reduction in waste because only those drugs actually consumed by an individual are billed.

Under the MMA and Title I regulations, post-consumption/retrospective billing arrangements are allowed, and should be accommodated, assuming they are managed in a manner that is compatible with all other Part D requirements such as formulary coverage and true out of pocket expense (TrOOP) processing.

- Network pharmacy providers are responsible for verifying that drugs dispensed to the beneficiary are covered under the beneficiary’s Part D plan. Because network-pharmacy providers utilizing post-consumption/retrospective billing will not submit the first claim to a Part D plan until after the drug has been dispensed, the pharmacy provider must employ another mechanism for verifying coverage in advance of dispensing. Formulary placement and prior-authorization or step-therapy requirements must be adhered to in order for Part D claims to be payable. Any long-term-care pharmacy bypassing real-time DUR edits must take responsibility for complying with any such requirements prior to dispensing drugs, or be prepared to absorb the cost of the drug. With the exception of first fills permitted under a plan’s transition policy for new beneficiaries, Part D plans may not be held responsible for payment of non-covered drugs that were dispensed without determining coverage beforehand. Likewise, neither Medicare enrollees, nor long-term care facilities should be held financially responsible for the cost of drugs that have not been dispensed in compliance with the plan’s formulary.

- In order to accurately calculate TrOOP expenses, post-consumption/retrospective billing must be done via a single-claim, Point-of-Sale transaction, HIPAA compliant format (i.e. NCPDP 5.1). The NCPDP 1.1 non-real time batch transaction standard cannot accommodate TrOOP calculations and cannot be used for Part D claims at this time. (We note that some software vendors are exploring technical enhancements to allow claims to be submitted in batch mode at some point in the future.) It is important to distinguish references to billing format standards from the common use of the term “batch billing”. If the term “batch billing” is used to refer to the one-time billing of a single claim at the end of the month via the NCPDP 5.1 standard despite multiple dispensing dates throughout the month, such billing is acceptable. If “batch billing” is used to refer to the non-real time NCPDP 1.1 standard, then it not acceptable for the Part D benefit.

- With respect to “date of dispensing” in the post consumption/retrospective billing environment, CMS understands that current practice is to use either the initial fill date for the month or the date of billing. While providers and plans are free to use either, CMS believes it preferable to use the initial fill date as the "date of dispensing" so that "early refill" rejections do not occur when individuals leave a facility and immediately get a prescription filled at a retail pharmacy. Accordingly, Part D plans should expect 30-60 day old claims from long term care pharmacies utilizing post consumption/retrospective billing software that enters the initial fill date at time of billing. (Note: Part D plans may want to confirm which date is being provided as the dispensing date so that they are not paying claims for drugs dispensed prior to January 1, 2006).

Notwithstanding real-time billing requirements for Part D, initial implementation challenges could require Part D plans and some long-term care pharmacy providers (such as state-run intermediate care facilities for the mentally retarded (ICF/MRs), Institutes for the Mentally Disabled (IMDs), and long-term care units affiliated with acute care hospitals) to develop interim solutions to ensure convenient access for residents of such facilities. In many cases, these facilities might have an in-house pharmacy that will not be prepared with the appropriate billing software for January 1, 2006. CMS does not expect this will prevent contracting with Part D plans when efforts are being made to become compliant. Consequently, Part D plans may need to accept delayed submission of initial claims for several months after the benefit begins until such providers can implement the required billing systems. This will require cooperation between both pharmacy providers and Part D plans. CMS expects such interim solutions to be implemented when necessary to ensure convenient access to the Part D benefit for enrollees residing in such long-term care facilities.